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14. ABSTRACT The purpose of the study was to gain new knowledge about the experiences of family members of service members who are experiencing symptoms of PTSD or severe depression. The study was intended to be multi-method, with an initial qualitative phase (Phase 1), and a follow-up longitudinal, quantitative phase (Phase 2). Substantial recruitment difficulties hampered the execution of the project. Multiple requests to loosen the inclusion criteria in ways that would not compromise the aims of the project were denied. Thus, we were only able to enroll 10 dyads in the male soldier/female partner group and 2 dyads in the female soldier/male partner group for Phase 1. Qualitative analysis of the 12 completed interviews revealed several themes with regard to difficulties with overall military lifestyle, personal struggles of spouses, issues related to deployment, behavioral health problems of service members, relationship and interpersonal struggles of service members, and recommendations for improvements.					
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Table of Contents

	<u>Page</u>
1. Introduction	4
2. Keywords	4
3. Body	5
4. Key Research Accomplishments	11
5. Reportable Outcomes	12
6. Conclusion	12
7. References	14

INTRODUCTION

This project focused on marriages/romantic relationships and family relationships of service members with significant risk for PTSD and/or suicidality. Social support is one of the strongest buffers against PTSD (Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003), and relationship difficulties have been cited as the most common trigger of suicides in service members over the past several years (Keuhn, 2009). Thus, a healthy interpersonal environment is key for service members who may be struggling with behavioral health problems. Unfortunately, spouses/partners of service members or veterans with symptoms of PTSD or depression have significantly elevated levels of psychological and interpersonal distress (Lambert, Engh, Hasbun, & Holzer, 2012). It also appears quite likely that parents and other close relatives of service members with PTSD or depression experience significant distress, but there currently are almost no empirical data about relatives other than spouses or children. Based on the clear interaction between individual psychological problems in service members and their interpersonal environment, the ultimate objective of the project was to gather data that would inform the future design of interventions for relatives of service members that would increase relatives' resilience and, consequently, their ability to provide support for service members. The purposes of this project were to: (1) identify the primary needs of relatives of high-risk (PTSD/depression) service members, and (2) identify potential distress and resilience mechanisms in these relatives. The original research project proposed two phases. Phase 1 employed individual interviews to (a) better understand the needs of romantic partners and (b) begin to identify needs of other types of family members (e.g., parents), who are rarely the focus of research. Phase 2 was to employ longitudinal assessment of service members and partners/relatives using interview and self-report measures to (a) validate information gathered in Phase 1 and (b) examine the longitudinal associations among service members' psychological functioning and the family environment. This information would, in turn, be used to identify primary targets for family intervention that can increase partners'/relatives' resilience and improve service members' psychological functioning. Due to extensive recruitment difficulties, Phase 1 remained incomplete, and Phase 2 was never able to be initiated.

KEYWORDS

PTSD
Suicide
Marriage
Family

BODY

Please note that tasks below refer to the newly approved SOW from the approved NCE (23 OCT 2014).

Task 1a. COMPLETED. Approval for all revised procedures were obtained on 17 DEC 2014.

Task 1b. COMPLETED. Manual revision was completed prior to IRB submission.

Task 1c. COMPLETED. Training was completed in DEC 2014.

Task 1d. COMPLETED. Eligibility screens were prepared and ready in early JAN 2015.

Task 2a. PARTIALLY COMPLETE. Eleven female spouses/partners were enrolled for Phase 1 interviews. Only two male spouse/partners were enrolled. No parents/other relatives were enrolled.

Task 2b. PARTIALLY COMPLETE. RAs completed interviews for all enrolled participants (13).

Task 2c. COMPLETED. Supervision meetings were held as needed, based on interview frequency and protocol issues.

Task 2d. COMPLETED. Transcripts were created for all interviews conducted.

One interview recording (from the female spouse/partner group) was faulty. Thus, 10 transcripts from the female spouse/partner group (producing a total of 186 pages), and 2 transcripts from the male spouse/partner group (producing a total of 42 pages) were created.

Tasks 3a-3b. COMPLETED. Coding was completed during Y6.

Coding by the PI and co-I yielded a large group of issues. Discussion of the issues resulted in a collapsing of several issues into related themes. This set of themes stretching across the interviews with spouses/partners was as follows: (1) spouses' difficulties related to deployment, (2) difficulties associated with Army lifestyle (outside of deployment), (3) stigma of behavioral health problems, (4) personal struggles of spouses, (4) soldiers' emotional/behavioral problems, (5) changes in personality and values, (6) relationship problems, (7) communication about deployment, (8) resilience factors, and (9) recommendations.

Detail about each theme is provided below.

Spouses' Difficulties Related to Deployment

Almost all spouses noted difficulties related specifically to deployments. Common themes across these concerns included:

1. The rapidly repeating deployments experienced in the early years of OEF/OIF were perceived as extremely difficult and distressing to soldiers and families alike.
2. The first deployment is often the most difficult, particularly with regard to figuring out communication (how often, what medium, etc.).
3. Figuring out how much to share about problems at home is difficult – trying to balance the partner's need to share, the soldier's need to know, and preserving a feeling of connection with not distracting the soldier or causing him/her to feel guilty or worried
4. Concern for safety of the soldier
5. Difficulty with the 'unknown' – lack of communication, information was reported as highly stressing to the family
6. Loneliness – separation from the person you love is difficult, regardless of preparation, etc.
7. Living with extended family (e.g., partner's parents) was often reported as helpful – both for emotional support as well as logistical support
8. A few spouses noted that, in some ways, deployment was helpful in forcing couples to actively work on communication (have to learn how to communicate well when you are separated for so long)

Difficulties with Army Lifestyle (Outside of Deployment)

Multiple spouses/partners endorsed difficulties that accompany a lifestyle in the military. These difficulties were perceived to impact the service members, spouses/partners, and the family. They were often couched as seeing the soldier put the "Army first, family second."

Some specific difficulties mentioned by multiple spouses were as follows:

1. Spouses having to subjugate his/her career and leisure needs to the demands of the military, due to frequent moves.
2. Disruptions to family life, such as canceled vacations (due to changes in work demands) and frequent interruptions during "off-hours," particularly related to cell phone calls/texts and emails.
3. Constant pressure to work toward next promotion causing excessive stress.

4. Service members sacrificing their own personal health to try to meet demands of military and family (e.g., by working more after family went to bed, thus creating chronic sleep deprivation).
5. Perception that soldiers frequently withhold discussing unclassified details about their struggles at work.
6. Difficulties with the excessive bureaucracy that often comes with military life (e.g., obtaining needed records, etc.).
7. A sense of 'broken promises' due to perceived constant changes in orders, assignments, etc.
8. The perception that, once the soldier retires, the military is "done" with that individual – the transition is extremely abrupt and difficult for soldier and family.
9. The level of difficulties vary by location and leadership. More remote locations were typically accompanied by a sense of greater hardship. Some spouses noted that effective leaders could reduce the negative impact (e.g., by attempting to help soldiers achieve work/family balance with more reasonable expectations of response time to emails, etc.).

Stigma of Behavioral Health Problems

These partners reported significant difficulties related to perceived stigma, such as:

1. Even if the Army at large attempts to reduce stigma attached to PTSD and other problems, individual units and members of those units continue to stigmatize those identified with problems
2. Fears of losing job and/or career advancement
3. Particularly difficult to admit problems if you are a leader, for fear of looking 'weak' to subordinates
4. Sense that Army does not always live up to promises (telling soldiers they'll get them help, but then delaying while they assign more responsibilities)
5. Many soldiers feel they need to just keep on going until retirement – but families have to live with them during that time (and the delay potentially makes it harder for the soldier to recover)
6. Access to treatment is difficult, sometimes often only comes after multiple appointments
7. In treatment, some soldiers felt judged, like the therapist thought they needed to just 'suck it up'

Personal Struggles of Spouses

All spouses discussed personal struggles related to being part of Army life and/or the soldier's PTSD. Primary personal struggles included:

1. Career difficulties (also mentioned above) leading to frustration, financial difficulties, and sometimes feeling purposeless
2. Feeling marginalized (by Army and/or soldier) – of secondary importance, and sometimes seen as a nuisance
3. Difficulties obtaining support for themselves, related to
 - a. Not having many friends, due to frequent moves
 - b. Being afraid to ask for help, as it could hurt the soldier's career
 - c. Feeling unable to ask the soldier for help, due to overwhelming work responsibilities and/or soldier's own behavioral health problems.
4. Trying to keep household running smoothly to minimize stress for soldier (e.g., handling all child-related activities, bills, household maintenance, appointments, etc.)
5. Trying to be on alert for possible triggers for soldier, to minimize potential reactivity
6. Feeling depressed – but also feeling like they should be able to “pull themselves up by the bootstraps”
7. Hard to be as supportive of the soldier as they want to be, due to their own mental health problems, leading to additional guilt
8. Some perceived Family Readiness Groups (FRGs) as extremely unhelpful, and/or too heavily influenced by the rank of the soldier (e.g., spouses of junior/enlisted feeling judged by spouses of more senior soldiers)
9. Male spouses noted additional difficulty of connecting with other spouses, almost all of whom were women

Soldiers' Emotional/Behavioral Problems

All spouses noted difficulties related to soldiers' emotional and/or behavioral health problems, such as:

1. Withdrawal/Numbness: soldiers seen as withdrawing, not connecting with spouses/families, using video games and/or TV to avoid interaction

2. Arousal: soldiers not sleeping well, easily startled by loud noises, stressed by traffic, jumpy, hypervigilant (e.g., having to sit with back to the wall, facing the door when in public)
3. Anger: snapping at children, snapping at spouses (some noted a perception that angry outbursts at home were, in part, due to the inability to express anger at work)
4. Drinking: daily drinking after work, difficulty controlling amount of drinking
5. Impulsive behavior: for example, buying a new car without any research or discussion

Changes in Personality and Values

Spouses reported perceived changes in soldiers' broader personality after deployments, including:

1. Perceived shifts in previously shared values (e.g., losing religion)
2. Less tolerant of/patient with others (particularly children)
3. More black and white thinking
4. More judgmental of others

Relationship Problems

Spouses noted several relationship problems, many of which are captured in other domains above. The most frequently referenced problems in addition to ones mentioned above (e.g., anger) were:

1. Reduced intimacy (less feeling of connection, less physical closeness), soldier withdrawing from communication
2. Parenting struggles: snapping at children, difficulty being with children
 - a. One male spouse noted the particular struggle of his wife seeming to feel burdened by children, then guilty for feeling burdened
3. Re-integration problems: soldier feeling un-needed at home after deployment; soldier intentionally disrupting kids' "routine" after deployment to "have more fun"; soldier feeling like family doesn't understand him or what he went through
4. Infidelity of soldier (reported by male spouse, as well)

Communication about Deployment

Some spouses commented specifically about soldiers' reluctance to discuss events that occurred during deployment. Although there was some understanding that events might have been seen by the soldier as classified and/or too horrifying to discuss, such withholding was seen as very damaging to family relationships. Spouses expressed desire for at least some level of sharing about the events that led to PTSD and other behavioral health problems.

Resilience Factors

Some spouses noted factors that helped them cope with the challenges described above. Among the main factors mentioned were:

1. Having grown up in a military family, which spouses felt provided a better understanding of what military life would be like.
2. A longer relationship history with the soldier prior to deployment and/or development of PTSD. The history was seen as providing more stability to the relationship, and allowing the couple to establish adaptive communication, etc.
3. Leadership who supported soldiers broadly, as well as specifically in regard to maintaining work/life balance.
4. Strong connection with extended family – both the partner's (for support) and the soldier's (for attempting to intervene and encourage the soldier to get help or change in some way).
5. Providing opportunities for spouses to volunteer and/or work with other families.

Recommendations

In response to a direct question about what would be helpful, spouses made several recommendations, as follows:

1. Family programs
 - a. For children – coping with deployment
 - b. For parents – helping children cope with deployment
 - c. For spouses/families – education on how to recognize symptoms, and how to get help for soldiers
 - d. More programs/support for spouses without kids
 - e. Establish couple/family programs in forums that are not chaplaincy based
 - f. Facilitate mentoring of “junior” spouses by more experienced spouses (without judgment)
2. Make programs more visible (especially to families, and to junior/enlisted)

3. Programs for soldiers
 - a. Help find ways for soldiers to share deployment experiences with spouses/families
 - b. Mandatory training for SMs on how to handle feelings, talk with families
4. Institutional changes
 - a. Instill greater respect of the need for family time (adjust work demands/expectations to allow for family time)
 - b. Provide some type of “step-down” time/program (like a “halfway house”) between deployment and return to family
 - c. Establish mechanisms so that seeking help does not jeopardize job
 - d. Provide care that is needed for SMs – prioritize medical/behavioral health needs
5. Keep American civilian population engaged, so that they know support is still needed
6. Expand educational opportunities for all spouses (particularly spouses of soldiers with lower rank)
7. Establish a veterans hotline that addressed veterans issues broadly (not just suicide)
 - a. Consider video component (e.g., Skype) for those who might want it, but don’t make this mandatory, for those who would prefer more anonymity

Task 3c. IN PROGRESS. Report is being finalized – completion was delayed due to waiting to attempt to enroll more participants.

Tasks 4-7. INCOMPLETE. All remaining tasks are in relation to Phase 2.

KEY RESEARCH ACCOMPLISHMENTS

- Approval of revised Phase 1 protocol.
- Completed enrollment for male soldier/female partner dyads.
- Completed coding of transcripts.
- Drafted final report of findings from coding analyses.

REPORTABLE OUTCOMES

- Draft of report of findings (will be finalized for submission to whatever point of contact is specified).
- Draft of portions of manuscript to disseminate findings (will be completed post-award).

CONCLUSION

Despite significant recruitment challenges and limited data, some interesting findings emerged from qualitative analysis of interviews with 10 female partners of male soldiers with PTSD symptoms, and 2 male partners of female soldiers with PTSD symptoms. Some of these findings mirrored prior findings in qualitative and quantitative studies (reviews by Campbell & Renshaw, 2016; Carter & Renshaw, 2016; Monson, Taft, & Fredman, 2009). Overall, spouses in our sample reported concerns about symptoms of PTSD and their manifestations in the soldier, reintegration difficulties after deployment, problems with communication (particularly related to restricted communication by soldiers), and stigma in the Army associated with PTSD and other behavioral health problems. They also endorsed significant psychological distress (primarily in the form of depressive symptoms) and perceptions of burden related to having to take on most of the household responsibilities. Related to deployment, spouses also reported concerns for the soldier's safety during deployment, difficulties determining the optimal frequency and media of communication during deployment, and struggles with how much to share with each other when communicating during deployment. Several spouses also reported that the rapid frequency of deployments during the early years of OEF/OIF were particularly difficult for soldiers and families. Other spouses also noted that the first deployment is typically the most difficult, as couples and families have to establish norms for communicating and coping.

Findings from our sample that have been less commonly reported in empirical literature include spouses' perceptions of changes in personality/values of the soldier (e.g., more judgmental, less tolerant/patient, changes in religious beliefs). In addition, the spouses in our sample reported several concerns that are less frequently discussed in literature focused on spouses of those with PTSD. For instance, many participants voiced "everyday" concerns related to Army lifestyle in general. These difficulties included things like frequent interruptions of "family time" due to late nights and/or cell phone communication (email, text, calls), bureaucracy, difficulty with frequent moves, and a perception that the soldier and Army prioritized the Army over the family. Concerns that were less commonly noted but also potentially important for consideration included a perceived lack of resources for spouses without children.

Of note, only two male spouses/partners participated, but their reported concerns were highly similar to those of female spouses/partners. Two additional concerns noted from these participants were (a) difficulty connecting with other spouses, almost all of whom were female, and (b) perceptions that women soldiers had an additional struggle with work/family balance, due to guilt related to their difficulty to fulfill the traditional role of a mother.

Notably, a number of spouses reported factors that helped them be more resilient in the face of the challenges they described. Primary sources of resilience included: (a) being able to rely on extended family (either of the spouse or the soldier) during and after deployment, (b) having grown up in a military family, which provided better context for and understanding of military lifestyle, (c) a longer relationship history with the soldier prior to deployment, (d) supportive unit leaders, who were attuned to the importance of work/family balance.

Finally, spouses made a number of recommendations to help address their struggles. These included expanded programs for coping with deployment, recognizing symptoms of PTSD, and communicating about experiences and feelings – they also recommended making these programs more visible and accessible (possibly even mandatory for soldiers). They also recommended institutional changes, such as promoting greater respect of the importance of family, greater access to treatment without fear of career repercussions, and some type of “step-down” time between the end of deployment and soldiers’ return to the family, to ease integration difficulties. Lastly, spouses recommended finding ways to maintain greater engagement of the American public, more educational opportunities for spouses, and a veterans’ hotline for broad issues, not just suicide.

Implications

It appears that, even when faced with PTSD and depression in soldiers, the family continues to be negatively affected by more common experiences, such as frequent moves, difficulty communicating, etc. Female spouses without children and male spouses are two groups who may experience even greater difficulty finding adequate supports. The resilience factors and recommendations that spouses described may be useful in helping families cope with difficulties.

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